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TO: Each Health Deputy

FROM: Cynthia A. Harding, M.P.H.
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SUBJECT: **CALIFORNIA CHILDREN'S SERVICES REDESIGN**

This is to provide an overview of the California Children's Services (CCS) program and proposed system changes that may impact the services currently provided by the Department of Public Health, Children's Medical Services Division, which administers the CCS program in Los Angeles County.

Background

The CCS program is a statewide Medi-Cal program providing diagnostic and treatment services, medical case management, and physical and occupational therapy health care services to children under 21 years of age with a qualifying CCS-eligible condition, such as severe genetic disease, chronic medical condition, infectious disease producing major chronic complications, or traumatic injuries. Examples of CCS-eligible conditions include chronic medical conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, and cancer and traumatic injuries such as those resulting from car accidents, fires, and gunshots. A child eligible for CCS must be a California resident, have a qualified CCS condition, and be in a family with an adjusted gross income of $40,000 of less. Children in families with higher incomes may still be eligible if the estimated annual cost of care to the family is expected to exceed 20 percent of the family's adjusted gross income. Counties, based on population size, are charged with administering the CCS program, either independently or jointly with the State. The program is funded by net County cost and state and federal revenue.

Under existing law, Medi-Cal beneficiaries are required to enroll in a Medi-Cal managed care plan. However, since 1994, CCS services have been exempted from being incorporated into Medi-Cal managed care contracts ("carved-out") and continue to operate on a fee-for service basis. Under this system, services are authorized, coordinated, and case-managed by county CCS programs. The current Medi-Cal managed care carve-out expires in all counties December 31, 2016.

Los Angeles County California Children's Services

Los Angeles County CCS provides diagnostic, treatment, rehabilitative, and care coordination/case management services for children and youth under 21 years of age with special health care needs. Los Angeles County has an active annual caseload exceeding 48,000 and serves over 70,000 children per year. The County's existing broad network of services includes over 11,500 individual CCS-paneled providers and 47 CCS-approved hospitals. Of these hospitals, there are six tertiary hospitals providing comprehensive, multidisciplinary, regionalized pediatric care to children and youth.

The Medical Therapy Program (MTP), which is an integral part of the CCS program, serves children and young adults under the age of 21 with certain eligible physical disabilities. The MTP provides medical case conferences, and physical and occupational therapy services to approximately 5,000 children at twenty-two Medical Therapy Units (MTUs) located in school settings throughout Los Angeles County. The MTP is the only program within CCS that provides direct services to children and youth. The MTP is also included in the managed care carve-out.

DHCS CCS Redesign Proposal: "Whole-Child Model"

As described above the CCS Medi-Cal managed care carve-out sunsets on December 31, 2016. On June 11, 2015 DHCS released a CCS redesign proposal, the "Whole-Child Model" which would be implemented in selected counties no earlier that January 1, 2017. In the remaining counties, DHCS would continue to work with stakeholders on alternative proposals and concepts to improve the care for children and youth receiving services through CCS. According to the model, the CCS managed care carve-out would be anticipated to end in the remaining counties in 2019. If enacted, the model would shift most of the CCS administrative and operational activities to selected managed care organizations contracted by DHCS.

On February 3, 2016 the State introduced a budget trailer bill to provide a vehicle for statutory changes to implement the Whole-Child Model. The bill would transition CCS services that are currently fee-for-service to Medi-Cal managed care plans contracted by the State. The bill would transfer related authority of the CCS program from the counties to the State; however, counties would continue to determine medical and financial eligibility for the CCS program, as well as provide physical and occupational therapy services. On March 14, 2016 the California Assembly Budget Subcommittee voted to deny the proposed trailer bill and defer the issue to the policy process. To date no policy bill regarding the DHCS Whole-Child Model has been introduced, but one is anticipated.

Potential Programmatic Impact of the Whole-Child Model

The potential programmatic impact of implementing the proposed Whole-Child Model, if fully implemented beginning in 2019, would be major, resulting in the severe reduction of key functions provided by county CCS programs. These major impacts are detailed below.

- ***Shift in responsibility for case management and care coordination services:*** The Whole-Child Model would require DHCS to contract with a managed care plan for the coordination and integration of Medi-Cal and CCS services for all CCS eligible children. This shift would eliminate the case management and care coordination services currently provided by county CCS programs.

- ***Shift in responsibility for services authorization***: Currently, nurse case managers authorize service in consultation with CCS physicians as needed. Under the Whole-Child Model, responsibility for authorization of services would shift to the contracted managed care organization. As managed care organizations have different interests than local health departments, the shift in responsibility for both case management and service authorization could impact the current practice of directing children to the appropriate health care source, regardless of location or cost.

- ***Uncertain future for the Medical Therapy Program:*** The Whole-Child Model indicates the retention of the MTP. However, MTP and the core CCS program are so closely intertwined it is difficult to determine the impact of loss of care coordination and service authorization responsibilities on the services provided through the medical therapy units. MTP administrative and service costs are funded 50% by the State and 50% through the County MOE by equal shares of County General Funds and Realignment Funds.

In addition to probable significant reductions in County staff, a shift to managed care for CCS services could result in significant negative impacts on children and youth with CCS-eligible special health care needs. These potential impacts are detailed below.

- ***Loss of expertise in care coordination for children and youth with special health care needs:*** Currently, nurses provide care coordination, case management, and service authorization for children and youth in the CCS program with oversight from physicians. The medical complexity of the majority of Los Angeles County's caseload requires medical oversight for case management. Administrative management does not provide the needed medical expertise to determine the appropriateness of the requested services.

- ***Disruption in existing services:*** Managed care plans will need to establish new networks of services, potentially disrupting the long-established networks of CCS paneled providers already in place. These current providers have established trust with the children and families served by CCS.

- ***Reduced patient choice and access to services:*** Managed care plans must establish contracts with providers. It is possible that the resulting networks may include fewer providers, thereby limiting patient choice and access.

- ***Reduction in service quality***: Currently, county CCS programs conduct case reviews in performing their care coordination and service authorization duties. Consequently, deviations from CCS standards are reduced, and when deviations are identified medical staff work with providers to resolve these issues. Although managed care contracts will be required to maintain CCS standards of care, it is unclear how these standards will be monitored and enforced under the Whole-Child Model.

- ***Erosion of CCS standards:*** In Los Angeles County, CCS works closely with the two managed care plans, LA Care and Health Net. The delegation of risk and responsibility by plans and plan partners to independent physician associations (IPAs) and medical groups could further narrow the networks of approved providers and dilute knowledge and compliance with CCS requirements. Strictly applied and rigorously monitored quality and performance standards assessed at the IPA and group level, in collaboration with the plan, as well as State and local CCS administrators, would facilitate maintenance of CCS standards.

Potential Fiscal Impact of the Proposed DHCS Whole Child Model

The exact fiscal impact of the proposed Whole-Child Model on Los Angeles County is difficult to quantify. If enacted the Whole-Child Model would shift most of the CCS administrative and operational activities to Medi-Cal managed care plans. The combined CCS Administration and MTP program budget for the FY 14-15 budget is $82,666,521, $17,795,211 of which is Net County Cost (NCC) funds. Currently, CCS has a total budgeted staff of 627.25 full-time equivalents (FTE), which includes a large cadre of public health and registered nurses, physical and occupational therapists, physicians, social workers, and patient and financial services workers.

Conclusion

Although the Whole-Child Model implementation timeline may extend until 2019, this is insufficient time to implement a complete redesign of the complex system of care currently in place for children and youth with CCS-eligible conditions. Further, many of the redesign goals, such as patient and family-centered and whole-child care to improve efficiency and cost effectiveness, are being met by innovative activities that are already underway.

Several projects are in progress in Los Angeles County to improve CCS' functioning within the current regulations and guidelines. Most notable is the Nurse Case Management Redesign Pilot Project. Implemented in February 2014, the project adjusts case management activities and interventions based on the level of medical complexity presented by the child's condition. Building on the pilot, CCS is implementing changes in the County that will enhance services to children and youth with special health care needs while also improving efficiency. The acuity-based case management model allows nurse case managers the flexibility to devote more of their time to cases with greater complexity, rather than providing care coordination and case management interventions through a standard approach. Efficiency will be increased under the model by shifting some routine data entry tasks to support staff rather than nursing staff.

DPH will work with the CEO's Intergovernmental and External Relations Branch on responding to the forthcoming legislation on the CCS redesign once it is released. If you have any questions or need additional information, please let me know.

CAH:aml

c: Chief Executive Officer
County Counsel
Executive Officer, Board of Supervisors